



Shropshire Safeguarding Children Board

Annual Report

2018 – 2019





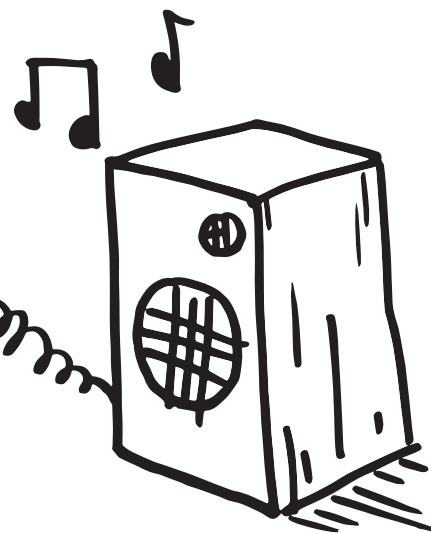
Shropshire Safeguarding Children Board

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Foreword by Ivan Powell (Independent Chair)

Welcome to the annual report of the Shropshire Safeguarding Children's Board (the Board) and thank you for your interest in the vitally important area of work.

It is the right of every child to be safe, to thrive and achieve their potential. Shropshire Safeguarding Children's Board brings together key partners from across the County to ensure we are working together effectively to prevent children and young people from coming to harm or that we take the necessary action where unfortunately this has happened. In addition we look to our communities who have an important role to play in being vigilant to the welfare of all our children and the information we give to the public is intended to assist in this.

During the reporting period the Board was subject to inspection by Ofsted and I am pleased to report was found to be 'good', more details are contained in the report, but from my perspective this judgement reflects what I see, as a strong, mature and committed partnership Board.

Shropshire partners are ambitious for children and have maintained a resolve for continuous learning despite the difficult challenges of austerity and organisational change which agencies continue to

encounter. One particular aspect presented as a consequence of organisational resilience is an inability for some to release staff to multi-agency training events, an area of focus for the Board in forthcoming years.

During the year we held a conference with our partners from the Keeping Adults Safe in Shropshire Board on the theme of exploitation. This was attended by 250 people from a range of agencies across Shropshire and we were privileged to hear from a number of speakers, particularly two survivors of childhood sexual abuse. We know from our recent experience that we need to continue to focus on the sexual exploitation of children within our broader exploitation work. We also know that we need to better understand some of those areas of exploitation which are more easily overlooked, for example, that society and professionals easily underestimate the threats experienced by young adolescent males and the complexities they face in receiving the services they require. It is important therefore that we continue to work with partners to increase our shared understanding and appropriate prioritisation of their needs.

In pursuit of this we have commissioned some independent review work to advise us on how we might improve our understanding of exploitation and how better to support victims through service changes.



Childhood neglect is also a significant issue in Shropshire and remains an area of sharp focus for the Board. During the forthcoming year we will be updating our Neglect strategy and exploring how this will support improved outcomes for children who suffer from neglect.

We can never wholly eliminate risk and during this year the Board has commissioned three serious case reviews to ensure that agencies have worked hard to learn from serious incidents. In two of the three cases a child lost their life and these losses are tragic. More detail of those reviews is contained within this report but I would like to formally acknowledge the involvement of family members, where they have so wished, to be involved in the review process thereby ensuring a high level of influencing required improvements.

I would also to place on record my thanks to those professionals who engaged positively with those reviews, with openness, transparency and a willingness to learn. In one of these cases Shropshire continues to seek to influence national policy regarding unaccompanied asylum seeking children who go missing. This work continues and will be reported on in next year's annual report.

Partnership safeguarding arrangements for children are subject to change following the Children and Social Work Act 2017 and the Local Authority, Police and Clinical Commissioning Group are currently in discussions to agree what the new arrangements will be as a consequence. Shropshire has a strong foundation of partnership working and the Board benefits from an experienced business unit to support this transition.

It is a privilege to act as Independent Chair and I would like to acknowledge the work of highly skilled and committed professionals and community representatives in this important area of work.



**Ivan Powell,
Independent Chair**

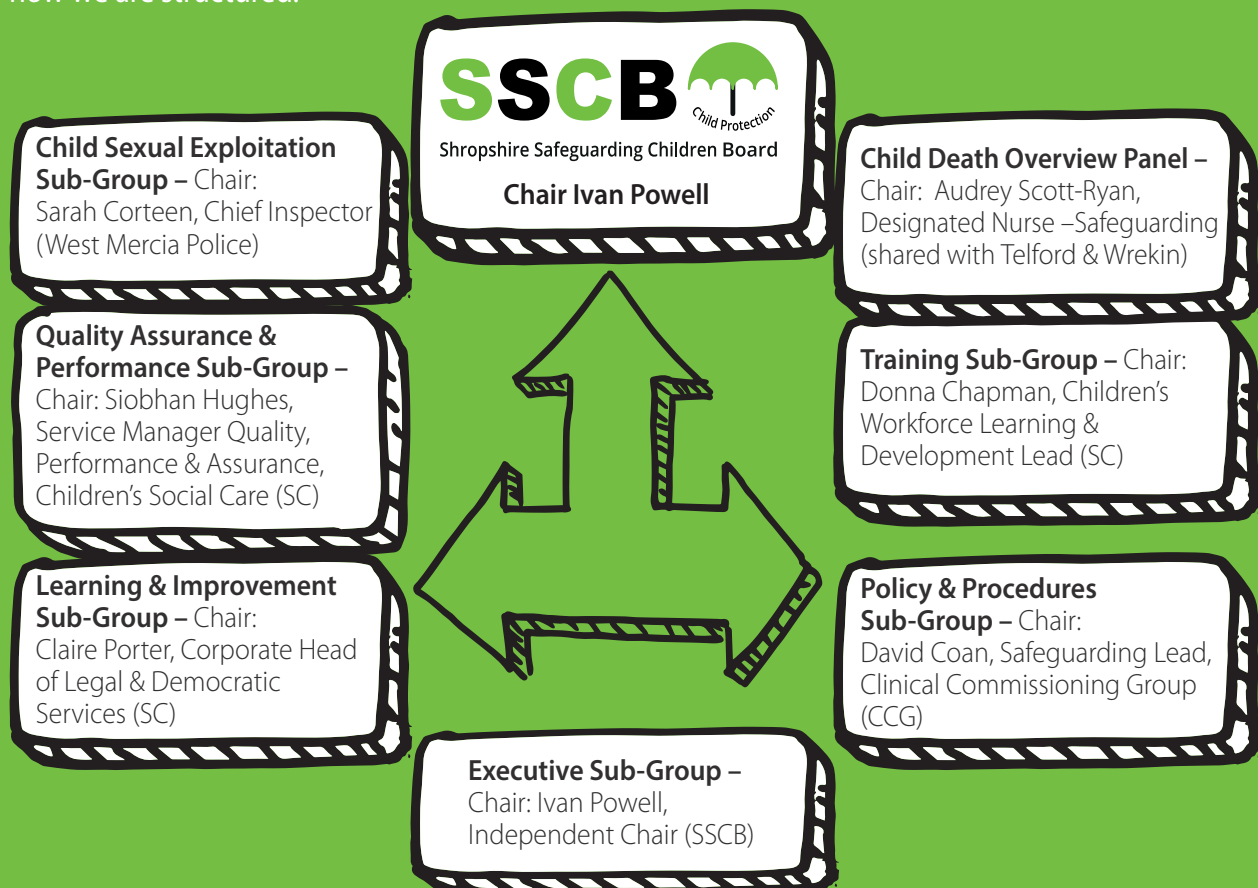


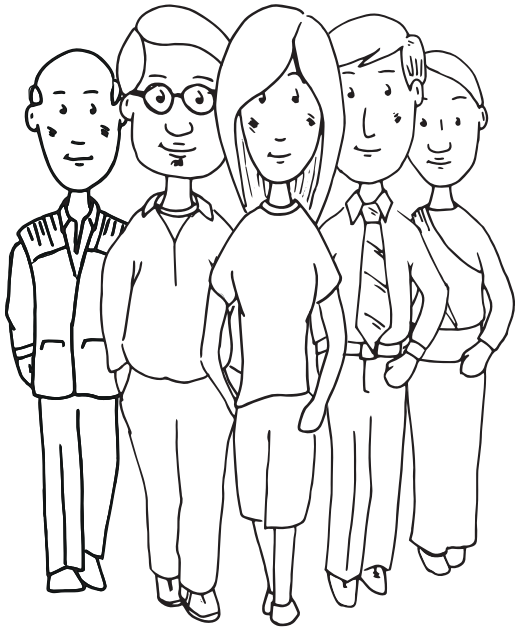


Introduction

The Shropshire Safeguarding Children Board is a statutory body established under the Children Act 2004 and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the county.

The Board carries out much of its work through a number of sub-groups and task and finish groups, supported by the Safeguarding Boards Business Unit. This is how we are structured:





Our groups are well supported by a wide range of agencies, including schools, colleges and voluntary sector organisations as well as the larger statutory organisations.

There are also a number of groups that contribute significantly to progressing the safeguarding agenda in Shropshire. These include:

- the Health Safeguarding Governance group, which brings together safeguarding leads from across all the NHS providers working in Shropshire and beyond its borders;
- the Private Providers' Forum, which promotes safeguarding of looked after children placed within Shropshire from elsewhere;
- the Schools Safeguarding Group, which provides a close link with schools across all phases, from early years to further education.

As part of Ofsted's inspection during September and October 2017, the inspectors also reviewed the effectiveness of the Board. The Board was rated 'good' which reflected the high standards held by the Board and commitment of its members. The Board did receive one recommendation as follows;

"To better enable an understanding of the strengths and weaknesses of performance and practice, ensure that there is appropriate analysis and commentary on the dataset made available to board members"

This is our update:

The Quality Assurance and Performance sub-group reviewed the data collection for the Board to make sure that measures were agreed by partners and that requests for data and commentary were made to the appropriate persons within each agency. Multi-agency data was provided to the partnership on a quarterly basis, however the analysis of partner agency data remains an area for improvement in order to provide a partnership wide picture of the effectiveness of safeguarding arrangements.





What we achieved this year

In our report for 2017-2018, we described a number of commitments for the Board to achieve. The list below helps to explain the effectiveness of our partnership arrangements.

We said we would...

... continue to raise awareness of Child Sexual Exploitation, particularly in areas of the county where there are lower rates of referrals.

What we achieved:

Child Sexual Exploitation briefings were held around the County. Specific areas of the County couldn't be referenced in sessions in order to avoid compromising disruption activity by those agencies involved.

We said we would...

... monitor and analyse performance against a revised exploitation scorecard and strengthen the joint exploitation sub-group.

What we achieved:

Exploitation performance measures were revised and data discussed and analysed at the sub-group. A joint Exploitation task and finish group was established to begin work on developing a joint response. An initial joint sub-group meeting was held in January 2019. Developments included establishing partnership wide definitions of exploitation and a learning briefing on criminal exploitation.





We said we would...

- ... support the development of and seek assurance that a mechanism for gaining the views of children who have been sexually exploited on their experiences of interventions/ support services.

What we achieved:

A closure template has been developed to seek young people's views at the end of an intervention. The findings of this will be reported back to the Child Sexual Exploitation sub-group.

We said we would...

- ... deliver a Personal, Social and Health Education briefing to include Child Sexual Exploitation, to all Independent Schools in preparation for PSHE becoming statutory from September 2019.

What we achieved:

Personal Social and Health Education briefings were delivered for all Independent Schools.

We said we would...

- ... review the capacity and approach used to provide enduring support to sexually exploited children.

What we achieved:

An Early Help Exploitation Lead was appointed in January 2019.

We said we would...

- ... revise the Neglect Strategy and review its effectiveness through performance data and a multi-agency audit planned for 2018-19.

What we achieved:

Work began in this year to revise and review the strategy. We will aim to complete this work during the next year.

We said we would...

- ... continue with the task and finish group to revise and analyse the Neglect data set.

What we achieved:

The task and finish group continued to meet and make revisions to the dataset throughout the year.



We said we would...

- ... on implementation of 'Liquidlogic', identify themes and patterns to help understand the effectiveness of managing neglect across the system, including Early Help, Step Up and Step Down and Child Protection.

What we achieved:

It was not possible to complete this action due to the delay in implementation of Liquidlogic

We said we would...

- ... clarity around governance arrangements for leading the domestic abuse agenda across the partnership.

What we achieved:

This area of work is still being developed and will be one of actions for next year. As we build stronger links with the Keeping Adults Safe in Shropshire Board, we are also thinking about our connections with the Community Safety Partnership

We said we would...

- ... evaluate the results of the voluntary perpetrators programme.

What we achieved:

This has not been achieved in this year but in the future, will sit under the responsibility of the Community Safety Partnership.

We said we would...

- ... review the impact of the Domestic Abuse Strategy.

What we achieved:

In May 2018, a multi-agency audit was carried out of families effected by domestic abuse. Three cases were graded as 'Good' and two as 'Requires Improvement'. Auditors commented that there was significant progress in practice regarding domestic abuse since the audit of this theme in June 2017. The Community Safety Partnership Domestic Abuse Forum commissioned SafeLives to help assess and improve the approach to tackling domestic abuse in Shropshire. In February 2019, their report made a number of suggestions about how to improve monitoring the strategy.





We said we would...

- ... provide more sophisticated performance monitoring to measure outcomes in relation to domestic abuse and its impact on children.

What we achieved:

The dataset has been revised to incorporate additional measures in relation to domestic abuse. However there remain some challenges with collecting some of this data, particularly in relation to understanding where domestic abuse may be a factor but not necessarily the predominant type of abuse.

We said we would...

- ... review the Training Strategy.

What we achieved:

The Shropshire Safeguarding Children's Board Training Strategy and Schedule was launched in this year. Please read the training section for more information about this.

We said we would...

- ... ask agencies to continue to promote multi-agency training as part of their workforce development strategies

What we achieved:

The Shropshire Safeguarding Children's Board Training Strategy and Schedule was There are many multi-agency training sessions run throughout the year. The number of staff trained evidences this well.

We said we would...

- ... ask agencies to ensure they continue to promote the completion of evaluations and reflect on the difference training makes to service delivery and children and families lives

What we achieved:

Evaluation is ongoing activity that happens at the end of every training session. Please read the section on training to find out more about this is done and what people have said about the training.

We said we would...

... continue to deliver and evaluate specialist learning events.

What we achieved:

Our specialist sessions were delivered to 427 people from 25 agencies. The training section explains what those sessions were.

We said we would...

... consider and manage a new Learning Management system upon the current system's renewal in December 2018.

What we achieved:

The learning management system was reviewed and kept in place as the Council system could not support external learners. It is due for review in December 2020.

We said we would...

... request agencies to assess themselves against the remaining four standards of the Section II audit as follows:

- Recruitment and selection
- Staff induction, training and development
- Complaints allegations and whistle-blowing
- Information sharing communication & confidentiality

What we achieved:

This happened as agreed and the themes are reported against the actions below.

We said we would...

... arrange a joint Exploitation conference with Keeping Adults Safe in Shropshire Board.

What we achieved:

The conference was held at Shrewsbury Town Football Club. The event was attended by over 250 delegates and the feedback we received was excellent.

There were a number of speakers at the event who gave us some real insight into these areas and told very moving stories about their experiences. During the afternoon there was a busy marketplace with over 20 stands and four, hour long workshops were run simultaneously.

97% of respondents advised that since attending the event they now have a greater understanding of the impact of exploitation and 90% of respondents advised that following their attendance on the afternoon workshop their confidence in the subject area has increased. Here's a powerful piece of feedback from the day:

'Having listened to lived experience - if they can stand and tell their stories we have a responsibility to do everything possible to stop exploitation happening!'

Videos and power-point presentations can be accessed to develop learning and improve practice at:

<http://www.keepingadultssafeinshropshire.org.uk/learning-resources/information-and-learning-resources/exploitation/>



We said we would...

... analyse completed audits by taking into account the following:

- Whether the self-assessment was completed fully
- Extent of evidence provided and whether this was robust
- Whether the self-assessed grade appeared justifiable (given the evidence)
- Whether there was evidence that the organisation is learning from quality assurance activity and acting on findings
- Risks evident from agencies self-assessment
- Innovative / good practice

What we achieved:

The findings of the audits were reported in October 2018 with key themes as follows:

- All agencies need to provide a grade as part of their self-assessment.
- The quality of evidence provided varied considerably so this needs to be improved.
- The majority of agencies uploaded some evidence, which provided improved assurance on previous S11 audit processes.
- There were very few real examples of evidence that demonstrated that practice is embedded.
- There were significant gaps in action plans where agencies had graded themselves as Requires Improvement.
- There was evidence of actions being completed from the previous peer review in particular work on child friendly complaints processes.
- There was a lack of evidence to demonstrate how agencies assure themselves that commissioned services are compliant with S11 standards.

We said we would...

... review proposals for quality assuring agencies, completed audits will be agreed by SSCB and implemented during 2018-2019.

What we achieved:

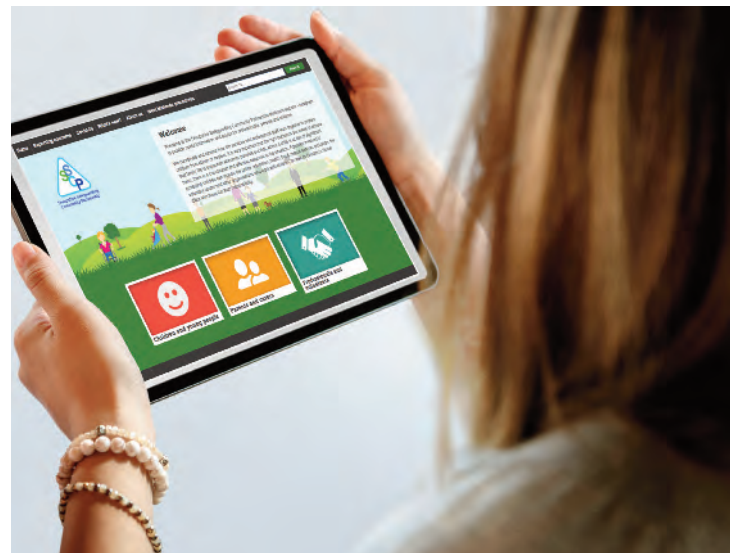
Unfortunately, the Peer Review didn't happen due to staff absence, competing workload and pressures. This is going to be incorporated into Challenge Days for partners.

We said we would...

... consider the use of one online system across the West Midlands to benefit agencies working across multiple LSCBs, to allow for cost efficiencies and to pool resources for improvement work across the region.

What we achieved:

A regional audit tool has been produced and phase 2 of the project is to consider an IT solution to support partners to collect and evaluate the data and produce an action plan for those areas requiring development. A region wide online solution should also reduce costs to the individual Partnerships and assist with the analysis of audits.





The effectiveness of these arrangements in practice

An effective Board understands both what it is good at, what it needs to work on and learn from. This report offers a balanced view of our effectiveness. It is easy to see that improvements need to be made by Partners in providing evidence about how they have embedded safeguarding into everyday practice. The training offer of the Board is excellent and wide ranging. The rigorous approach and analysis of course evaluations provides assurance that the right modules and range of training is being delivered to Shropshire's workforce to support an effective safeguarding system.

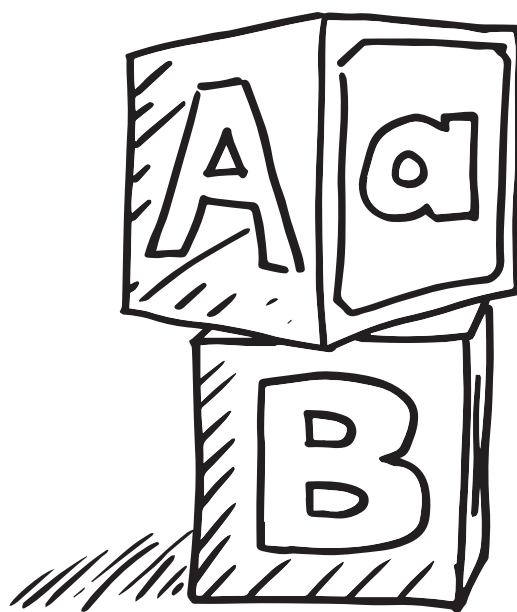
The Board (through the work of the Business Unit) are an active member in the West Midlands Safeguarding Procedures Group. The group has devised a two-year rolling programme for the revision of procedures unless learning, or changes in legislation mean we need to make more immediate changes. The procedures that were revised and updated during 2018-2019 included:

Level A statutory procedures:

- Changes required following the publication of Working Together to Safeguard Children 2018

Level B regional procedures:

- Information Sharing
- Trafficked Children
- Children Missing from Home and Care
- Recruitment, Supervision & Training
- Children Affected by Gang Activity



Level C local procedures:

- COMPASS Pathway, Podcast and Multi-Agency Referral Form
- Sexting guidance
- Self-Harm Pathway and Guidance
- Domestic Abuse Pathway

The Regional Safeguarding Procedures Group regularly reviews the analytics of the procedures site to assure itself of the effectiveness of the procedures pages and to pick up any issues of usability. There were 39,571 visits to the West Midlands Safeguarding Procedures site across the region during 2018-2019.

Shropshire have three of the “**Top 10 Downloads**” listed across the region:

- Child Sexual Exploitation Risk Assessment tool = 445 downloads
- Suicide Prevention Care Pathway = 344 downloads
- Thresholds Guidance = 299 downloads

This is felt to be a direct result of the promotion of certain tools and pathways in multi-agency training and learning briefings and is reflected across other Boards in the region that take a similar approach to raising awareness of certain procedures.

Our work on Policy and Procedures offers further evidence of effectiveness and preparedness for being up to date with legislative changes and emerging themes in practice.

There is of course α BUT...



Serious Case Reviews

(undertaken when a child dies or is seriously harmed because of abuse) make us realise we are not always as effective as we would want to be in protecting children from death and serious injury.

Child E – Published December 2018

This Serious Case Review was commissioned following the death of Child E to consider the way in which agencies worked both individually and together in this situation.

Child E's parents separated shortly after Child E's birth and contact and residency had been determined by the Court following the breakdown of their relationship. E lived with their mother, and also spent time with their father, although this contact had been stopped by mother three months prior to E's death. In September 2017, E was found dead at the maternal family home. Subsequently, E's mother was arrested and charged with their murder. E's mother was found guilty of murdering E who was 7 years old at the time of their death and she was sentenced to life imprisonment.



Lessons learned

Shropshire Council's Children's Social Care team has since reviewed the referral process and the use of the multi-agency written referral form where there are concerns about a child, in order to provide clarity and effective application of the referral pathway. These arrangements were implemented in January 2019.

Training and learning opportunities for the multi-agency workforce have been developed to include factors highlighted in the report such as:

- factors to be considered and assessed in circumstances where separated parents make allegations about the welfare of their children;
- experiences and barriers to working with fathers; and
- enabling professionals to reflect on the approach to providing a whole family focus.

The Shropshire Safeguarding Children's Board has also worked with the Local Family Justice Board and CAFCASS to ensure timely and consistent arrangements are in place where there are safeguarding concerns for children who are going through the family court process.

Child C – Published November 2018

This Serious Case Review was commissioned following the death of Child C, who was later found to be an adult. Child C was an unaccompanied asylum-seeking child who was thought to have been trafficked into the UK and went missing from their foster care placement within days of being placed. They remained as a missing person, believed to have been within the West Midlands area until notification of their body being found in Derbyshire.

Lessons learned

This review has identified a number of issues about:

- agencies' awareness of the indicators of trafficking and associated risks,
- their assessment of young people who present as unaccompanied asylum seekers,
- the management of risk in cases where children remain missing for a long time and
- the impact of a child's status on how they are managed and reviewed.

Examples of improved practice include the following;

- photographs are now taken of all young people on admission to care,
- an emergency response plan is now in place to be implemented in the event of a large number of unaccompanied young asylum seekers arriving at the same time,
- photographs and fingerprints are taken by West Mercia Police which has been the nationally agreed approach for police response to Unaccompanied Asylum Seeking Children who are at risk of going missing'.
- weekly intelligence sharing meetings are being held with partners from West Mercia Police on children missing from care and contact has been made with relevant embassies to locate the families of these children.

West Mercia are seeking to implement a new procedure on young migrant Clandestine Entry into the UK in line with the principles of Operation Innerste, which will include an enhanced package to work more effectively with partners and foster carers. It is the intent of West Mercia to consult partners across the geographic area prior to launch.



West Mercia Police have reminded staff of the managing the transfer of missing person's investigations contained within the "College of Policing Approved Professional Practice" and continue to work with the national policing lead to improve transfer processes.

Children's Social Care now maintain the looked after status of missing children who are unaccompanied asylum seekers and hold statutory reviews in accordance with national guidance. The service has introduced a Unaccompanied Asylum Seeking Children Worker and have made significant improvements in the timeliness of assessments with assurance being provided to the Board.

Refugee Action has been commissioned to provide additional support to Unaccompanied Asylum Seeking Children and trafficked young people.

It is important to note that prior to this case Shropshire had no previous experience in responding to a situation like this. Since that time significant improvements have been made across agencies.

A number of national recommendations were also made which the Board is still awaiting a response from central government in spite of proactive chasing.

Child F – currently underway

(we had a result from National Panel 18/19)

Following consultation with the National Panel, a learning review is being conducted on Child F, a new born who sustained serious non-accidental injuries at just 21 days old. Both parents were teenagers and concerns had previously been raised about their ability to parent.

The review is focusing on how agencies have worked together following:

- the notification of the pregnancy,
- the diagnosis of the father's learning needs/learning disability and
- concerns about parenting.

The findings and learning of this review will be reported in next year's annual report.



G Children – currently underway

This Serious Case Review examines the circumstances of agency contact and involvement with six children in a family who experienced neglect and maltreatment to varying degrees.

The decision to initiate this review was taken in June 2018 when the full extent of the harm was acknowledged and required legal intervention. Due to not wanting to disrupt other proceedings and a need to better understand the complexity of the case, it was agreed to delay the start of the review process.

The review began in earnest in February 2019 following the appointment of an Independent Reviewer and will be reported on in full in next year's annual report.



Impact on Children and Families in Practice (including hearing the voice of Children and Families)

The Board understands impact by undertaking multi-agency audits.

Impact of Domestic Abuse:



A multi-agency audit was carried out of families impacted by domestic abuse who were known to probation services and had been open to Children's Social Care.

The audit identified that risk assessments were being carried out on the impact of domestic abuse on all cases. Work carried out appeared to have been effective in reducing risk for families and had resulted in cases being closed to Children's Social Care.

Liaison between Probation and Children's Social Care was very positive and contributed to a reduction in risk. An example of good practice given was that Probation had included adhering with the Child Protection Plan in the plan for the offender.

Impact of Child Sexual Exploitation and Transition to Adulthood:

This theme was chosen in recognition that our Child Sexual Exploitation pathways have strengthened for young people, but that this support ends at the age of 18. One case was graded "Outstanding", one "Good with elements of Outstanding", two were graded "Good" and one "Requires Improvement".

It was evident through the audit that the pathway has been embedded in Shropshire for children and young people and the right steps were being taken by Children's Social Care and other agencies to keep young people safe.

There was evidence of transition planning for young people that were turning 18 years old, however it was not specifically about Child Sexual Exploitation.

The lack of resources which follow young people into adulthood in Shropshire was a concern to partners. Good relationships with a professional that was able to address issues of exploitation was seen as key to reducing risk for young people.

Impact of Child Sexual Abuse in the Family:

This audit was conducted as part of a Joint Targeted Area Inspection in November 2018.

Seven children were selected for audit by inspectors. The purpose of this was to evaluate the quality of practice in achieving good outcomes for children and young people who are at risk of or experiencing child sexual abuse within the family environment.

Of the seven cases selected, two were evaluated as “Good” and five were judged as “Requires Improvement”.

The findings included:

- In five of the seven cases referral for action was timely with appropriate responses by partner agencies.
- In two of the cases auditors have highlighted some delays in referral.
- In six of the seven cases it is the view of auditors that risk had been appropriately identified and children were safe.
- Assessments were felt to be timely, robust with consideration to background history, risk and protective factors.
- Learning included although assessments had sought views of the child and mother these needed to be acted upon.
- The audit highlighted effective family engagement across a range of cases. This is evident from visits to the family, engagement at meetings, engagement with plan, effective direct work, young people’s attendance at meetings and the child’s views informing planning and good relationships with children in school.

Impact of Parents Separated in Private Proceedings:

This audit was conducted following the findings and recommendations from the Serious Case Review of Child E. Three cases were graded “Requires Improvement” and 2 were graded “Good”. Common features of the cases included domestic abuse between parents and parental substance misuse.

Areas of good practice included:

- The voice of the child was heard by social workers and other professionals and wishes and feelings were clear.
- Successful engagement and intervention from Shropshire Drug and alcohol services.
- Contact with both parents was a focus for workers.

Areas of improvement included:

- Domestic abuse was not consistently considered fully for both parents. Where both parents have alleged to be victims of domestic abuse, they should both be referred to domestic abuse services.
- Lack of resources in different languages in undertaking domestic abuse work.
- Agencies were found not to be aware of the new duty to refer to Housing Services at the earliest point when families are faced with eviction.

Overall it was found that action had been taken to keep children safe. Parents were found to be supported with substance misuse issues, however there were felt to be improvements in considering and supporting both parents in relation to domestic abuse.



Data for SSCP infographic 2018-2019

463 Early Help assessments completed

281

Number of families allocated to Targeted Early Help

Contacts to COMPASS
13,760

Referrals to Children's Social Care

1,996

(amended figure – reporting changed – this ties in with nationally reported data)

Referrals to Children's Social Care increased by

38%

from 2017/18 to 2018/19. In Shropshire, the proportion of referrals with no further action is low (c. 2%)

Children in Need

1,590

A Child in Need is one who has been assessed (or is being assessed) by children's social care to be in need of services.

Shropshire has seen a

32%

increase in Children in Need from March 2018 to March 2019.

Rate of CP Plans

32 in 2018

55 in 2019

(number 328, 165 of those with Neglect as latest category of abuse)

The rate of Child Protection Plans has increased

72.6%

from 31st March 2018 to 31st March 2019. At 31/03/19 Shropshire had a higher rate than comparators at the same point.

Number of children on a Child Protection Plan

328

at 31/03/19 – latest categories of abuse %:

Neglect: **50%**

Emotional Abuse: **35%**

Sexual Abuse: **8%**

Physical abuse: **<5%**

Multiple: **<5%**

Rate of Looked After Children

396 Looked After Children in this year.

57 (per 10,000 children) on 31/03/18 and

66 (per 10,000 children) on 31/03/19

The rate of Looked After Children has increased

15.7%

since 2017/19. At 31st March 2019, Shropshire had a higher rate than statistical neighbour (59) and England (65) averages at the same point.





Neglect Priority area

Progress

The Early Help Service are now taking the lead for reviewing the Neglect strategy. A task and finish group was established in March 2019, with a plan to hold monthly meetings to review the strategy over a six-month period.

Areas for development:

The task and finish group will be considering:

- Widened membership to include strategic membership as well as operational;
- Governance, legislative requirements, research and workforce development are all detailed in the current strategy but need updating;
- The existing links to workforce development may not include the Early Help workforce development plan;
- Strategic links to Welfare Reform/Housing etc. need to be added to the strategy;
- Learning from the current SCR and multi-agency audits
- Tracking of cases identified within Early Help and Children's Social Care;
- Adverse Childhood Experiences; and the
- Use of screening tools.

Neglect data 2018-2019

Percentage of Child Protection Plans under category of Neglect

50%

As at 31st March 2019.
Primary category of need.

Neglect identified in
% of assessments

34%

Higher than stat
neighbours (23%) and
national average (18%)

Exploitation of Children

Much of our work on Exploitation has been explained in this report. In order to bring it to life more, here's are a couple of young people's stories (no real names have been used in this report):

"Person A" is a young person who was at risk of harm. There was evidence that they were going to flee the country and was involved in numerous gang rape situations. West Mercia Youth Justice Service and Children's Social Care put a plan together to keep them safe and prevent them from leaving the country. "Person A" engaged with an intensive programme of work. At the end of their time with the West Mercia Youth Justice Service, they were accessing education, attending therapy and receiving sexual health intervention.

Exploitation data 2018-2019

89 The number
of exploitation
referrals

Gender split
Female 81, Male 8

Level of risk:

Low 25,
Medium 49,
High 14,
Being exploited 1

**Social Work Assessments
where Child Sexual
Exploitation (CSE)/Gangs
identified as a Risk Factor**
108 CSE, 53 Gangs

Emerging challenges such
and child sexual exploitation
(CSE) and child criminal
exploitation (CCE) are
becoming identified more
often in children being
assessed by Social Care

"Person B" was a troubled young man who had come to Shropshire from Cambridgeshire

and was living at a flat provided by a local housing provider through Housing Options. They grew up in a family where there was drug misuse and he moved away from home and 'arrived' in Shropshire on the promise of work in the agricultural industry which never materialised.

Very soon after being offered temporary accommodation, the flat was being used by a criminal gang as a base for the dealing of drugs. The Police carried out a welfare visit to "Person B" but they were reluctant to engage at that time.

Eventually, the Police gathered enough information to allow for an application for a drugs warrant at the address. The Police took housing colleagues with them when the warrant was executed and although evidence of drugs activity was found, the main purpose was to remove "Person B" from the control of the criminal gang.

The housing provider put their own safeguarding in place backed up by a Police Risk Management Plan. "Person B" was visited often to begin with, was referred to Child and Adolescent Mental Health Service and the Doctor.

"Person B" is now being supported with their mental health, is now employed and has joined a local football team. They had not come to the Police's notice in relation to any drugs activity in the past 6 months.

During 2018 -2019, Young Addaction have supported seventy-six young people who have disclosed criminal or sexual exploitation, in either one to one support, group sessions or drop-ins. The service has two dedicated staff; one for criminal exploitation and one for sexual exploitation. This is what one of their young people had to say:

"Thanks for all your help. I couldn't have come this far without you, no more drugs, no more shit lads who use me for sex and I'm getting on much better with my mum. I actually like her again."



Training

The Shropshire Safeguarding Children's Board Training Strategy and Schedule was launched in this year. It provides a framework for single and multi-agency training to enable professionals, volunteers and partner organisations to get the skills and knowledge to work effectively to safeguard children.

Among other things this strategy has:

- placed training activities within a clear statutory and policy context
- had due regard to the strategic priorities of the SSCB
- clarified roles in developing the children's workforce
- actively considered, local and national learning from cases to equip the workforce to help keep Children safe from abuse

Training Activity

Between 1 April 2018 to 31 March 2019 the Training Co-coordinator, some Training Pool members and commissioned organisations delivered training to 7530 learners.

Face-to-Face Multiagency Training

A total of 61 events delivered to 1441 delegates in this period.

Training strategy



Training Activity cont.

Module	No of Events	No of Delegates
Universal	21	564 across 20 agencies
Domestic Abuse Briefings	14	
Introduction to Substance Misuse	3	
Raising Awareness of Safeguarding Children	4	
Targeted	30	450 across 22 agencies
Child Protection Conference & Core Groups	3	
Compromised Parenting	2	
Child Sexual Exploitation	4	
Domestic Abuse & its Impact	3	
Neglect Graded Care Profile 2	5	
Protecting Children & managing the Challenge	4	
Suicide Prevention	5	
Working with Substance Using Parents	3	
Specialist	10	427 across 25 agencies
Exploitation Conference	1	
Graded Care Profile 2 Review Updates	3	
Sudden Infant Death Syndrome	1	
Train the Trainers	1	
Training Pool Updates	4	

14:18

eLearning Training

Total of 16 modules available & completed by 185 learners in this period.

Module	No of Learners
An Introduction to FGM, Forced Marriage, Spirit Possession & Honour Based Violence	18
An Introduction to Safeguarding Children	50
Awareness of Domestic Violence & Abuse	11
Basic Awareness of Child & Adult Sexual Exploitation	5
Collaborative Working: a Whole Family Approach	9
Equality & Inclusion in health, Social Care or Child & Young People Settings	1
eSafety	3
Hidden Harm – the effects of parental substance use on children	13
Parental Mental Health	8
Safeguarding Children from Abuse by Sexual Exploitation	10
Safeguarding Children in Education	5
Safer Working Practices	7
Self Harm & Suicidal Thoughts in Children & Young People	22
Trafficking, Exploitation & Modern Slavery	8
Understanding Pathways to Extremism and Prevent Programme	8
Working with Children with Disabilities	7



It is essential that we use evaluations from every session to prove how effective the training has been at meeting the set aims of the session and whether the training has increased the attendee's confidence in dealing with safeguarding Children. Evaluations provide the Training Co-coordinator with a valuable source of information about the attendee's thoughts on the quality of the training experience and suggestions for improving future training. These comments inform the reviews of each of the multi-agency training modules. Here are some examples of what people have said:

'Much more confident when handling a disclosure and I now know exactly what to do.'

'I can think about a couple of work scenarios that have safeguarding dimensions so considering these in the context of today's learning has influenced who I might approach in future.'

'I now have a more in-depth knowledge of the referral process and what happens following the referral.'

'I will be more prepared to attend a child protection conference in future and be able to provide information to service users about what to expect.'

'As an adult survivor of abuse, I was extremely anxious about my ability to cope with this course, let alone get much from it. However, due to the expertise, sensitivity and professionalism of the course leaders, I gained a massive amount of confidence personally and feel really empowered in terms of supporting the children that I work with.'

'I now have a better insight into substance misuse and can now use what I have learnt when working with my families.'

Three months after attending any multi-agency, universal or targeted training, learners are asked to complete a second online evaluation which has been developed to evaluate the impact the training has had on their professional practice and ultimately to children, young people and their families. These are only a few examples of what people said:

"I talked to a parent regarding concerns about their child watching horror movies/playing games which are inappropriate for their age."

"I was able to be more sure in myself, that people can move on following a period of domestic violence and I believe this has impacted on my work with a number of clients."

"I work with many parents that try to deflect their parenting by focusing on themselves and their issues and therefore putting the focus back to the child and their lived experiences is key."

"I attended a (child protection) conference very soon after training. I usually feel nervous and worried about questions directed at me and my answers. I came to conference fully prepared after having already submitted my report on the correct paperwork. I knew what was expected from me and I was relaxed and delivered my part in the process with confidence. I feel I contributed to the outcome with my background knowledge of the family."

"I have already used the strategies learnt. The same week I did the first day of training (self-harm) I had 2 students come to me and talk to me about suicide. I was able to work with our safeguarding team to go through the suicide prevention plan. The week of completing the second day (suicide prevention) I had another case referred to me to assess. We went through the suicide prevention plan framework (using your worksheets) and completed a support plan for the individual student."

"The course has enabled me to see the difficulties faced by young carers and very young children living in difficult circumstances. I was also able to see situations from the point of view of the parent. This helped me to empathise and ask more poignant questions."

"I have used this during my 1-1 clinic when a mum who had left the family home some time ago with her children and couldn't understand and didn't realise how it had impacted on her older son as he was clingy but also demanding of her attention."

"This tool has helped me to show a family what changes needed to be made to the home conditions."

"Understanding the risk assessment tool has helped my understanding of issues when seeing young people, especially looked after children. Also, I have used the BROOK traffic light tool for normal sexualized behavior and passed on information about it to trainee junior doctors to improve their knowledge."





This rigorous approach and analysis provides assurance that the right modules and range of training is being delivered to Shropshire's workforce to support an effective safeguarding system.

It is only possible to deliver this many training sessions to this quality because of the dedication and enthusiasm of the professionals who make up the Training Pool.

The partnership appreciates that trainers and their employers continually manage the pressures of their usual workload with SSCP training delivery commitments. A total of 5904 learners completed Raising Awareness in Safeguarding and Child Protection training. We would particularly like to thank:

- Shropshire Community Health NHS Trust
- Shropshire Clinical Commissioning Group,
- Shrewsbury Town Council
- The Hive
- Shrewsbury Town in the Community
- Shrewsbury and Telford Hospitals NHS Trust
- Enhance
- Young Addaction
- Shropshire Youth Association
- Shire Services
- Independent Care Providers
- All education settings
- Connexus housing group
- Shropshire Council



Changes to published arrangements

The Board was working towards developing the new Partnership arrangements in preparation for submission to the Department for Education in April 2019 as required by Working Together to Safeguard Children 2018.

A new governance group “Shropshire Safeguarding Partnership” was established in this year.

What we want to achieve next year

There will be many areas of work that will continue next year as we implement the new Partnership arrangements but our particular focus will be on:

- The Neglect of children
- Continuing work on our joint priority (with the Keeping Adults Safe in Shropshire Board) of Exploitation
- Strengthening our relationship with the Keeping Adults Safe in Shropshire Board and other Partnerships

2019-20

Closing statement

I hope you've taken the time read about the work of the Shropshire Safeguarding Children Board and its partners and what they have been doing to try and keep children safe from harm.

This report helps to remind us why we need to constantly try and improve how we work together. If nothing else, I hope you've read the case reviews and stories. We all need to do what we can to help prevent harm to children.

I appreciate that the stories are difficult to read but I'm sorry to say it does happen in Shropshire. We should never get used to it or become complacent, but we do need to accept it as something that happens in Shropshire.

Please make sure you play your part in keeping Children safe and help us to stop it.



Thank you.
Ed Potter
Portfolio Holder –
Children's Services

SSCB 
Shropshire Safeguarding Children Board



Shropshire Safeguarding Children Board

Annual Report

2018 – 2019

